

<b>Case Number:</b>	CM15-0055589		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	03/17/2010
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York, Pennsylvania, Washington  
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 43 year old male, who sustained an industrial injury on 03/17/2010. He has reported subsequent neck pain and was diagnosed with cervical radiculopathy, myofascial pain syndrome and strain injury. Treatment to date has included oral pain medication, physical therapy, cervical epidural injections and multiple trigger point injections. In a progress note dated 02/05/2015, the injured worker complained of neck pain radiating to the bilateral upper extremities. Objective findings were notable for decreased cervical and lumbar range of motion, hyper-tonicity, spasm and tenderness of the cervical, thoracic and lumbar spine. A request for authorization of Percocet was made.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Percocet 10/325mg 1 tablet QID as needed #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 78-80, 91, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, 9792.26 Page(s): 74-80.

**Decision rationale:** This injured worker has chronic pain with an injury sustained in 2011. The medical course has included numerous treatment modalities including surgery and use of several medications including narcotics, NSAIDs and gabapentin. Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit of 5/14 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of percocet is not substantiated in the records. The treatment is not medically necessary.